Treatments Without Diseases

BY THOMAS SZASZ

In the psychiatrically correct view, mental illnesses are "just like bodily illnesses"; in fact, they are authoritatively declared to be "brain diseases." The truth is that they are not. In medicine, there are diseases and, *sometimes,* treatments for them. In psychiatry, there are no diseases; nevertheless there are *always* treatments; that is, procedures declared to be "therapies" for what, in fact, are *diagnoses*. The disanalogy between bodily disease and mental disease generates many confusions, perhaps most importantly the false belief that antipsychotic drugs function analogously to antibiotic and antihypertensive drugs.

There are objective criteria to determine whether a person has or does not have, say, a case of acute gonorrhea. This makes it reasonable to ask whether an antibiotic drug, say penicillin, is effective against gonorrhea. However, it is not reasonable to ask whether an antipsychotic drug, say Zyprexa, is effective against schizophrenia, because there are no objective criteria to determine whether a person has or does not have this alleged disorder. This is why it is futile to debate whether one or another psychotropic drug "works." All we can know is whether a particular mental patient likes or does not like to take a particular psychotropic drug; whether a particular family member likes or does not like his "loved one" to receive a particular psychotropic drug; and so forth.

With respect to so-called mind-altering drugs, whether heroin or Haldol, introducing the *coercive powers of the state* into the controversy about the therapeutic effectiveness of one or another such drug further complicates the situation. We regard clerical-religious coercion as evil independently of its alleged theological benefits. This was not always the case and is not the case now in other parts of the world. Similarly, we have a choice between regarding clinical-psychiatric coercion as good because it is "therapeutic" or evil regardless of its alleged therapeutic benefits.

In my view, the ultimate arbiter of whether a psychiatric drug helps or harms a patient is the patient himself. And the best way to determine whether a person truly believes that a psychiatric drug helps or harms him is by attending to his behavior, not his words, much less the words of psychiatrists and pharmaceutical companies.

If a "mental patient" seeks a drug and pays for it, then it helps him; if he avoids the drug and is unwilling to pay for it, then it harms him. It is foolish to call entire classes of drugs "therapeutic" or "toxic," good or bad, safe or dangerous, because the effect of a drug depends very heavily on the dose—as well as on the user and the social context.

From an economic-political point of view, drugs—especially psychiatric drugs—may be divided into two groups: 1) substances that people want to take and are willing to pay for, such as sleeping pills, and 2) substances that people do not want to take and are not willing to pay for, such as antipsychotic drugs. Not coincidentally, the substances people reject are the drugs typically administered to them against their will.

Drug Bonanza

Because many drugs affect the brain and the brain affects our behavior, the use of neuroleptic and other psychiatric drugs has proved to be a bonanza not only for pharmaceutical companies, psychopharmacologists, and personal-injury lawyers, but also for psychiatrists eager to testify in tort litigation about mental illness, drug treatment, and their supposedly scientific insight into people's "dangerousness to self and others" (self-mutilation, suicide, assault, and murder). These fake

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experts also fall into two groups that we may call "pro-" and "anti-drug" psychiatrists.

The pro-drug psychiatrists claim that psychotropic drugs treat mental diseases, often manifested by suicide and homicide. When a patient does not take his "prescribed medication" and then kills himself or others, these experts blame the patient's behavior on "untreated mental illness." The pro-drug psychiatrist attributes agency to mental illness and non-agency to the person he calls "mental patient"—and testifies in court that the patient was not legally responsible for his lawless acts.

The anti-drug psychiatrists claim that psychotropic drugs cause or predispose to suicide and murder. When a patient takes his "prescribed psychiatric" medication and kills himself or others, the anti-drug psychiatrists blame the patient's behavior on the psychotropic drug. They attribute agency to certain psychotropic drugs (but not to others, such as alcohol and nicotine) and non-agency to a patient whom he regards as a victim of psychiatric malpractice—and testifies in court that the drug company that manufactures the drug (stigmatized as "Big Pharma") is guilty of negligent homicide.

Members of the two groups resemble one another in a crucial way: neither treats the patient-subject as a responsible moral agent. I maintain that neither mental illness nor psychiatric drugs cause suicide or murder. Killing—oneself or others—is a voluntary act for which the actor is responsible.

Pro- and anti-drug psychiatrists also resemble one another in their misuse of the concept of causation. There is an important difference between the way a drug such as Seconal (a barbiturate) causes sleep and the way a drug such Zyprexa (an antipsychotic) "causes" suicide. Sleep is a biological condition. Suicide is an action. To be sure, an antipsychotic drug may cause tormenting inner tensions that may "drive" a person to kill himself. But many of life's vicissitudes—divorce, disabling illness, death of a loved one—may do the same. Coerced drugging is a moral and political evil, even if it has no biologically harmful effects. If it does, the evil is compounded.

"If you miss the first buttonhole," remarked Goethe, "you will not succeed in buttoning up your coat." There are times, however, when missing the first buttonhole is the politically and socially correct thing to do. I believe we live in such a time.

The modern psychopharmacologist is like the man who inserts the first button into the second buttonhole and then tries to make the garment fit. What is the first buttonhole? The nature of the problem for which people take, or are forced to take, psychotropic drugs. What is the second buttonhole? The sacred symbol called "mental illness." Today, the person who makes a profession out of fastening the garment "scientifically" (but incorrectly) is richly rewarded, while the person who insists on fastening it correctly (but "unscientifically") is dismissed as an uncompassionate charlatan.

Legal-Social Context

Modern psychopharmacological treatment must be situated in its proper legal-social context. What is that context? It is a society in which the moral legitimacy of psychiatric coercions and statist drug regulations—exemplified by drug prohibition, prescription laws, and the criminalization of self-medication—are taken for granted. The parameters they set must not and cannot be questioned. The "scientific" psychopharmacologist—supported by the government (National Institutes of Mental Health) and the pharmaceutical companies—accepts the conceptual premises and coercive practices of psychiatry: mental illness is a medical illness like any other; the imprisonment of the mental patient is a medical treatment like any other. He validates psychiatry as a medical specialty and psychiatric drug treatment as a type of medical chemotherapy.

The result is the socially accepted pretense that the relationship between a patient with a mental illness and an antipsychotic drug is "just like" the relationship between a patient with an infectious disease and an antibiotic drug. This is a lie. Instead, the relationship between a forcibly "medicated" mental patient and the psychotropic drug resembles the relationship between a woman forcibly subjected to coitus and the aggressor's sexual fluids. Coerced drugging is a form of "therapeutic" rape.